EARLY PALLIATIVE CARE ALONGSIDE CURATIVE-INTENT BLOOD CANCER CARE: DEMONSTRATING THE VALUE OF THE UPSTREAM INTERDISCIPLINARY TEAM!

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INTRODUCTION

Patients with hematologic malignancies are less likely to receive specialist palliative care than patients with solid tumors, but are more likely to die in the hospital or receive chemotherapy at the end of life. Studies suggest that hematologic oncologists feel competent to manage complex symptoms and view palliative care as "end of life care," conflicting with treatment goals. Here we highlight the advantages of early interdisciplinary palliative care consultation in a patient with acute myeloid leukemia (AML).

CASE PRESENTATION

Setting: Lancaster General Hospital is a 590 bed facility in Lancaster, PA. Hematology/Oncology Specialists (HOMS), of the Ann B. Barshinger Cancer Institute, is the largest hematology/oncology practice in Lancaster. HOMS cares for 150-200 patients with hematologic malignancy each year and does induction, locally, for 5-10 patients each year. Patients with hematologic malignancies are routinely followed by an RN navigator.

Palliative Medicine Consultants (PMC), a program of Hospice & Community Care, is an inpatient consulting service composed of a certified palliative medicine physician, nurse practitioner, chaplain and social worker. PMC completes more than 1100 inpatient consultations annually.

Case: Our patient was a 67 year-old man with a new diagnosis of AML who was hospitalized in March 2013 for induction chemotherapy with curative intent. The hematologic specialist consulted PMC two weeks into his admission for symptom management. The patient's intractable pain and debilitating anxiety were impairing his tolerance of treatment. He was demoralized by a prolonged diagnostic course, loss of independence and uncertain future. Aggressive symptom management, spiritual support and counseling from the palliative physician, RN-Navigator, chaplain and social worker contributed to his successful induction course. When re-hospitalized for consolidation treatment, PMC navigated family discordance regarding plan of care in collaboration with Hematology. This intervention helped to facilitate stem cell transplantation in accordance with the patient's goals and resulted in remission. Relapses in January and May, however, required salvage chemotherapy. PMC readdressed goals of care when performance status declined and further curative treatment was no longer possible. Code status was changed to DNR, and he went home to enjoy a vacation with family. In August 2014 he suffered severe sepsis and pancytopenia. PMC, having already established a trusting relationship with the patient and family, rapidly facilitated hospice consult and discharge, fulfilling the patient's wish to die at home.

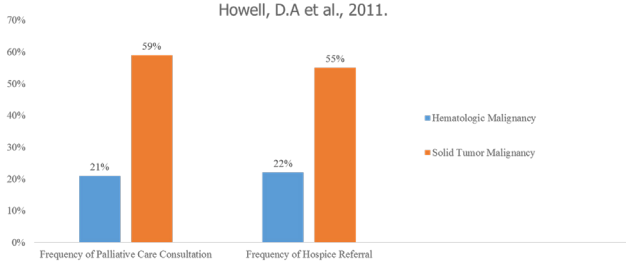
PALLIATIVE CARE AND HEMATOLOGIC MALIGNANCIES

Current Practice in Hematologic versus Solid Tumor Malignancy

- Less frequent palliative care consultation: 21% vs 59%
- Later palliative care consultation: 14 days prior to death vs 47 days
- Less frequent hospice enrollment: Half as many patients referred
- Later hospice enrollment: 10.9% die within 24 hours of enrollment, 36% within 7 days
- Increased in-hospital death, with escalating interventions
- Many unmet psychosocial needs
- High burden of physical symptoms

Palliative Care and Hospice Referral: Hematologic Malignancy versus Solid Tumor Malignancy

Howell, D.A et al., 2011.



Effects of Hematologic Malignancy or Treatments

- Prolonged/recurrent hospitalizations
- Frequent in hospital deaths
- Change in physical functioning
- Change in role functioning: limited work or household functions
- Impaired sexual functioning
- Depression, anxiety
- Caregiving burden: high levels of anxiety and unmet needs reported
- Substantial negative impact on HRQL from aggressive treatments
- Somatic Symptoms similar to solid tumor malignancies, throughout treatment, including:
  - Fatigue
  - Pain
  - Anorexia
  - Mucositis
  - Cough
  - Alopecia
  - Fevers
  - Headache
  - Diarrhea
  - Nausea/vomiting
  - Sleep disturbance
  - Cognitive impairment
  - Bleeding
  - Infection

Potential Benefits of Palliative Care in Hematologic Malignancy

- More frequent advance care planning and goals of care discussions
- Improved symptom management
- Reduced patient distress
- Improved quality of life
- Reduced caregiver anxiety, depression, distress, burden
- Increased satisfaction for patients, families, hematologists
- Increased/earlier hospice referral

Barriers to Palliative Care in Hematologic Malignancy

- Persistent confusion about the distinction of palliative care and hospice
- Inadequate availability of palliative care providers
- Lack of physician training in establishing and communicating achievable goals of care
- Perception that palliative cannot be involved with potentially curative treatments
- Sudden, unexpected transitions
- Absence of a clear transition between the curative, life-prolonging and palliative phases of disease in some patients.
- Hospice benefit may preclude potentially palliative interventions including transfusions, forcing choice of palliative versus curative

CONCLUSION

This case demonstrates that concurrent palliative care is helpful alongside curative-intent cancer-directed therapy.

We therefore recommend palliative care consultation for patients with leukemia who are undergoing induction chemotherapy, for aggressive symptom management, comprehensive counseling and assistance in decision-making.

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